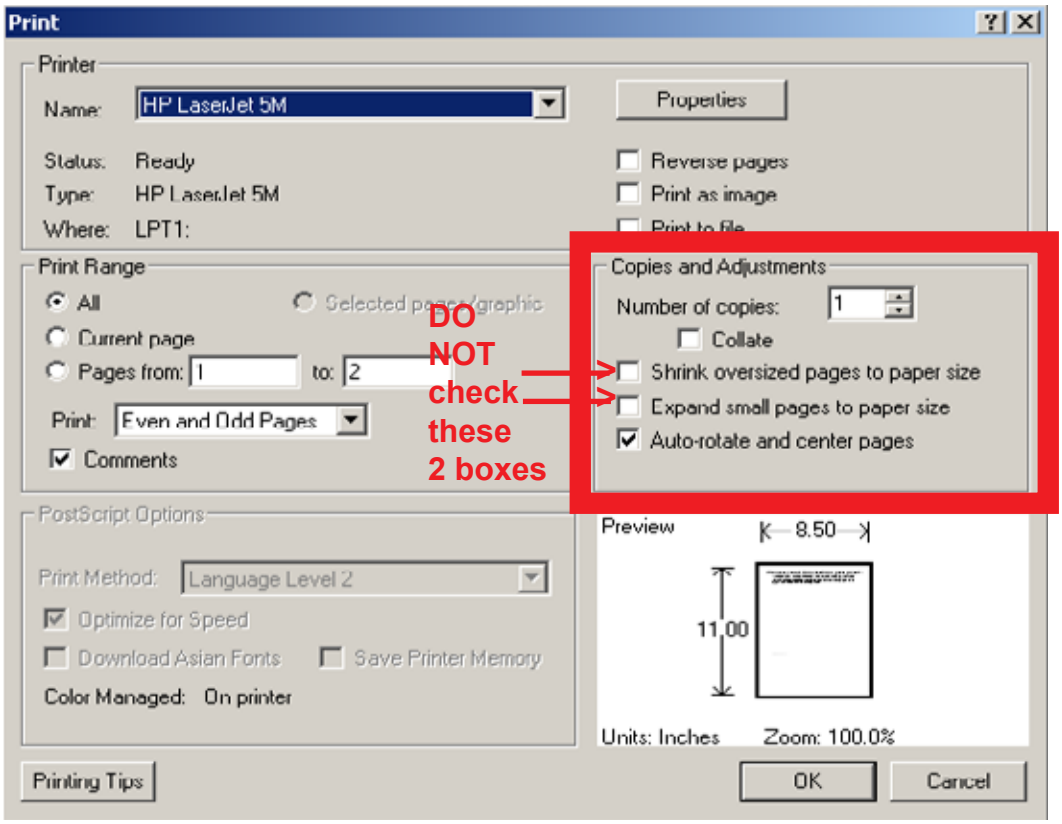
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Chiropractor Initial License Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to PO Box 1099, Olympia, WA 98507-1099.

Cut along this line and return the form below with your completed application and fees.

Chiropractor

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 641-032 (REV 6/2006)

1F 0252020000 00140

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

General Instructions–Chiropractic Licensure Washington

An applicant shall provide:

____ 1. An official transcript and diploma certified by the registrar, from an approved chiropractic college.

____ 2. Official transcripts from pre-chiropractic schools showing successful completion of at least two years of liberal arts and sciences study.

____ 3. An official certificate of proficiency sent directly to the Commission from the National Board of Chiropractic Examiners, Parts I, II, III & IV.

____ 4. Completed official application.

Instructions for Section 6 of application:

List all time frames from pre-chiropractic colleges and all summer breaks.

Example:

Bellevue Community College ..... 9/94 to 5/95

Summer break—traveled ..... 6/95 to 8/95

Washington State University ..... 9/95 to 5/96

Summer break—food server ..... 6/96 to 8/96

Chiropractic College ..... 9/96 to present

____ 5. **Non-refundable application fee of $300.00**. Return enclosed Revenue Section card with check made payable to the Department of Health.

____ 6. Verification of licensure status from all states where applicant has been issued a license to practice chiropractic. Verification is required whether license is active or inactive.

- Forms may be duplicated as needed.
- Check with state/province to see if a fee is required before you send in form

____ 7. Applicants must complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8. Sign section 3 on application form.

____ 8. Social Security Number is required on application.

Upon receipt of your application an acknowledgment/deficiency letter will be sent.

You will have 20 days from the date of receipt to complete and return the following:

1. Examination booklet
2. Answer sheet
3. Comment sheet

Your chiropractic license will be issued after successfully passing the Jurisprudence examination with a minimum score of 95 percent. **Please allow two weeks for processing.**

The license will be mailed to the last address on record. All address changes may be made in writing, or by calling the Customer Service Center at (360) 236-4700.

Licensure By Endorsement

RCW 18.25.040 authorizes the commission to grant licensure for endorsement to individuals to practice chiropractic under the laws of any other state, territory of the United States, the District of Columbia, Puerto Rico, or province of Canada, if the commission determines an applicant has qualifications that are substantially equivalent to the requirements in this section.

____1. Completed official application and **$300.00 non-refundable application fee**.

____2. Verification of licensure status from all states where applicant has been issued a license to practice chiropractic. Verification is required whether license is active or inactive. (Forms may be duplicated as needed.) (Check with state/province to see if a fee is required before you send in form.)

____3. Applicants must complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8. Sign section 3 on application form.

____4. Social Security Number is required on application.

Upon receipt of your application an acknowledgment/deficiency letter will be sent.

After all documentation has been received and the application is complete, the Jurisprudence Examination will be mailed. You will have 20 days from the date of receipt to complete and return.

You will return the following:

1. Examination booklet
2. Answer sheet
3. Comment sheet

Your chiropractic license will be issued after successfully passing the Jurisprudence examination with a minimum score of 95 percent. **Please allow two weeks for processing.**

The license will be mailed to the last address on record.

Mailing Instructions

Application and fee will be mailed to:

Chiropractic Commission
PO Box 1099
Olympia, WA 98507-1099

All correspondence and supporting documents will be mailed to:

Chiropractic Commission
PO Box 47869
Olympia, WA 98504-7869

“Washington state law and department of Health policy prohibits employees from receiving any gifts, gratuities and/or favors. Any offer of private benefit to an employee that is intended to influence a public decision is bribery and violates federal and state law.” (Reference RCW 42.18.320(2)).

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only	
ISSUANCE DATE:	
LICENSE #:	

Registration #

Application For Licensure
Chiropractor

☐ **Application Fee–$300** ☐ **Preceptorship–$100**

Please Type or Print Clearly— Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE NAME

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be released upon public request as it is the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change.

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS)	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW)
( )	— —

GENDER	BIRTHDATE (MONTH/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male		

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list full name(s):

2. Preceptorship

Preceptor	, D.C
Washington License Issued	(5 year minimum)
Preceptorship Program	Chiropractic College
Date Approved	☐ Proof of Malpractice Insurance (attach)

3. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

4. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

5. Professional Training And Experience

List all states where credentials are or were held. (Previous credential to include license, certification or registration.) Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	CERTIFICATE		METHOD OF LICENSURE	CURRENTLY IN FORCE
			YR ISSUED	NUMBER		
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES

☐ I have never been licensed to practice Chiropractic in any jurisdiction.

6. Professional Training And Experience

List in chronological order all colleges, universities, chiropractic school(s), and experience. Include all periods of time from pre chiropractic school to the present, whether or not engaged in activities related to chiropractic. (Attach additional 8 1/2 x 11 sheet if necessary).

NAME AND LOCATION OF INSTITUTION, PLACE OF PRACTICE OR OTHER	FROM (MO/DAY/YR)	TO (MO/DAY/YR)	DEGREE/CERTIFICATE AND DATE RECEIVED, NATURE OF EXPERIENCE OR SPECIALITY

7. Letters of Recommendation

No person is expected to sign this recommendation who does not know the applicant personally, and who is not willing to supply additional information concerning his or her character, and reputation, upon request from Health Professions Quality Assurance.

To: Health Professions Quality Assurance
State of Washington

This is to certify that I have known _____ for _____ years,

from _____ to _____. To the best of my knowledge he/she is of

good character and reputation.

Signature _____ Date _____

Address _____

To: Health Professions Quality Assurance
State of Washington

This is to certify that I have known _____ for _____ years,

from _____ to _____ . To the best of my knowledge he/she is of

good character and reputation.

Signature _____ Date _____

Address _____

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature _____ Date _____

Signed and sworn before me on _____ by _____
PRINT APPLICANT'S NAME

Notary Public in and for the state of _____

VOID WITHOUT NOTARY SEAL HERE

My appointment expires _____

_____
NOTARY NAME PRINTED

Official Use Only

Washington State Records Center

Washington State Department of Health

Out-Of-State Verification of Chiropractic Licensure

The Chiropractor listed below if applying for a license to practice chiropractic in the state of Washington. The Chiropractic Quality Assurance Commission requires that this form be completed by each jurisdiction in which he/she holds or has held licenses. Please complete the form and return it to the address below. Thank you.

Department of Health
Chiropractic Commission
PO Box 47869
Olympia, WA 98504-7869

Name _____

Birthdate _____

License # _____

I hereby authorize you to release the following information to the Washington Chiropractic Quality Assurance Commission.

_____
SIGNATURE OF APPLICANT

To assist the Commission in evaluating the above doctor's application, we would appreciate receiving the following information.

Name of Licensee _____

License # _____ Date Issued _____ Current? ☐ Yes ☐ No

License was issued on the basis of:

National Board Waiver _____

Examination _____

Reciprocity/Endorsement (indicate state) _____

Other: _____

Has applicant's license ever been suspended or revoked? ☐ Yes ☐ No

If yes, for what reason?

Has a complaint regarding this doctor ever been presented to your Board? ☐ Yes ☐ No

If yes, is the investigation still in progress? ☐ Yes ☐ No

If not, what was the Board's final action? Please attach information and pertinent documents.

(Board Seal)

Signature _____

Title _____

State Board _____

Date _____

This form may be duplicated as needed.

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Links to Chiropractic Websites

There are two forms needed from the National Board of Chiropractic Examiners' (NBCE) website:

1. The NBCE Part IV Transcript Request Form to release a transcript of your most recent Part IV score. It is available at:

   http://www.nbce.org/pdfs/transcript_req_Part_iv.pdf

2. The NBCE written exam transcriipt request form to release your written exam test scores is available at:

   http://www.nbce.org/pdfs/transcript_req.pdf

The above forms utilize Adobe Acrobat Reader, which is free.

The link to the NBCE home page is: http://www.nbce.org

The link to the Washington State Department of Health Chiropractic Commission home page is:

https://fortress.wa.gov/doh/hpqa1/hps3/Chiropractic/default.htm